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the CHILD

LEARNING TO LIVE TOGETHER

New Haven experiment in neighborliness

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THE Day family of New Haven, Conn., packed their belongings and joined the wartime migrant families of the country in 1942, when Dr. Harry Luther Day was commissioned in the Army.

In the next 2 years they traveled from one airfield to another, through 14 States. But they traveled a far greater distance than actual miles, over a long, long road from their secure New England moorings back to raw, primitive prejudices and discriminations exposed in the churning populations of war-born communities.

Mrs. Day and the children found themselves migrants, among the 6,000,000 other migrants created by war, living in unsavory quarters because there was no other place to be found, in crowded housing projects, or trailer camps. This New Haven family was one small fragment of America—America in the crucible of change, becoming aware of some of its own weaknesses and searching for new strengths.

When, in 1944, her husband was sent overseas, Mrs. Day and her three children came back to their home in New Haven.

Gertrude Hart Day looked about her at her own neighborhood, her own community, with a fresh eye of observation. At her very doorstep could be found many of the tangled problems to which she and her children had been exposed. People within a stone's throw were subjected to prejudice and intolerance because they were "different."

If changes were to take place, Mrs. Day felt, the logical starting point was right in her own neighborhood. Earlier experience as a social worker stood her in good stead. She sought out others, in the parent-teacher association to which she belonged, in the churches—wherever groups were to be found—and invited them to talk things over. At first only a handful came, meeting in one another's homes. As they considered some of the things they might do together as a neighborhood group, barriers of racial and religious differences gradually disappeared, particularly as the group centered upon what they could do for children.

How the project grew

The first need was for a playground—there was little space for the children to play after school. The neighborhood group found a yard that had once been a playground, pooled their resources and got the cooperation of the board of education in equipping it for use.

The informal group then became a neighborhood council. They moved from filling one simple need, upon which all agreed, to another. The next thing was a nursery school, which they called the Neighborhood Nursery School. They organized it on an interracial basis. The equipment and setting were simple; the school set up in a family home.

But from the beginning the educational standards were high. The staff was carefully chosen, with advice from the Clinic of Child Development of the Yale University School of Medicine and from the New Haven State Teachers College. It was a good nursery school and has continued on the highest educational level.

From that small beginning, within a single neighborhood, gradually has developed what is known as the New Haven Neighborhood Project. It has taken that name because all its activities are carried out on a neighborhood basis (a neighborhood being recognized as a grouping of some 1,800 persons living within natural boundaries). The project now includes three nursery schools (a fourth is to be opened in the fall, and a fifth is in prospect); a summer play school for older children; a book project, with reading and study groups; and three neighborhood councils sponsoring a variety of activities.

It has become a significant experiment in building understanding among people of different races and faiths and breaking down prejudice, with children as the starting point. After about a year and a half the experiment was taken under the sponsorship of the National Conference of Christians and Jews.

The project is a try-out of democracy at the level of the neighborhood and the community. While its basic motivation is building fellowship and tolerance among people of different races, this emphasis is never deliberately imposed. The children lose sight of the fact that a favorite playmate's skin is dark. He rates because he can build a good block house or tell exciting stories. Contact in normal situations brings understanding.

In the summer play school last year 80 children swam and hiked and played together. They represented 16 different nationality backgrounds; three races, white, Negro, and Asiatic; and the three major religious faiths in this country. Many of the white children never before had come face to face with Negro children of their own economic background; 80 percent of them never had mingled and played with them. The Christian and Jewish children, although meeting in school, had rarely mingled outside of it. But they forgot, as they had fun together, that skins were white or black or yellow, or religious faiths different.

Not only are the roots of this community experiment deeply embedded in the neighborhood, but in most of the activi-

Children are a starting point toward understanding among people of various races and faiths.

ties the atmosphere remains that of home and family. The executive headquarters, as well as the largest of the nursery schools, the Neighborhood Nursery School, are in the Day family home. Mrs. Gertrude Hart Day is director of the project. The house is an appropriate setting. It has the flavor of New England—it is rambling and vine-covered, with wide lawns shaded with old elms and great copper beeches. Inside, it is filled with things long lived with. The friendly living room with its book-lined walls is the kind of room in which you might expect to see a family like the Alcotts, Jo and Amy and Beth sprawling before the fireplace . It was, in fact, built by a writer, Ik Marvel, author of "Reveries of a Bachelor," popular a half century ago.

Whole family takes part

The nursery school is found to be a logical core of all the other activities of the project. First, because it interests all ages. Big brothers and sisters in junior high school make toys and paint furniture for use in the school. Parents meet in the nursery school and learn to know each other. Meeting together as parents to compare their mutual problems, studying together or working together, mending broken toys or painting battered furniture, differences disappear. People find themselves knit together around common needs.

More, in fact, has been done for the parents than for the children in this New Haven experiment. Children have a way of accepting each other. With them it is a matter of building a better tomorrow of tolerance and understanding.

The nursery school itself is an educational laboratory. Not only do children of different racial groups attend, but exceptional children are included so that their problems may be studied and mothers helped to bring about adjustments. It is hoped to expand this work if funds can be secured for the special staff required.

The supervisor of all the nursery schools is a capable Jewish mother, deeply interested in the project from the outset. One of the staff members of the Neighborhood Nursery School is a Negro, a gifted musician, well-trained for teaching, and with a rare understanding of children.

The other two nursery schools are in quite different settings and sections of the city; this has definite advantages for the experimental purposes of the project. One is in a housing project, Farnum Courts, in a neighborhood of mixed racial groups. The other, Summerfield Nursery School, is in a church-owned building in a modest neighborhood. It belongs to the people in a very special way. The young people of the church mended and painted the furniture and equipment. The men painted the walls and the women made curtains and provided some of the equipment. Local merchants donated rugs and other furnishings. While both these schools have simple settings and equipment, the supervisory and teaching staffs are of the same high grade as in the Neighborhood Nursery School.

In the fall a new venture, it is hoped, will be a nursery school in a public school. The principal has invited the experiment and the school authorities are carefully considering it. If undertaken it will represent pioneering in a fresh field, and if it proves practical and successful may make educational history in New Haven and the State. The project members have their hopes high.

There is a move to start a fifth nursery school in—a fire house! That would truly be an adventure. Going to school under the same roof with real-for-sure fire engines and firemen heroes would make any 3- or 4-year-old the envy of his peers.

The nursery schools are open 3 days a week. A day at home between school days is looked upon as having definite advantages, and it meets the objections of those who feel that young children should not be too much away from parental care.

Each of the nursery schools is related to a whole pattern of neighborhood situations and, even more broadly, intermeshes with community situations. The New Haven project schools are fortunate in having the resources of the Clinic of Child Development of the Yale University School of Medicine, the pediatrics department of the same school, and the Department of Education of Yale. When personnel are considered, guidance is sought from these sources, and they are continually drawn upon for consultation.

Close relationship also is maintained with the New Haven State Teachers College and the local council of social agencies, the appropriate agencies being appealed to when problems in their

fields are revealed in either the nursery schools or the neighborhood councils. Referrals of mothers whose children need nursery-school service are often made to the project schools by the council of social agencies.

An over-all intergroup neighborhood council, working closely with the National Conference of Christians and Jews, serves as the policy-making, program-planning, fund-raising body of the project. The council operates through a series of subcommittees dealing with such subjects as tension situations, program resources, study groups, literature, and fellowship activities.

Two simple principles have guided the leaders of the New Haven project at every step. One is: "Start slowly, and build upon genuine interest"; the other, "Don't start anything unless enough people are interested to carry it through." Interest may be expressed by nothing more than the contribution of a book or of a few hours of time, and still be real.

From this kind of neighborhood-rooted interest have grown a number of activities, all having the same underlying motive of building better human relations. One of these is the United Through Books project. This has developed because some of the members of neighborhood councils felt a need to attack ignorance and intolerance through knowledge. A collection of books has been made on interfaith and interracial topics. The exhibit library is set up before meetings of various organizations such as parent-teacher meetings and veterans groups, and provides material for home-study and discussion groups.

The summer play school is one of the happiest activities carried out under the auspices of the project. This takes in children from 5 to 12 years, divided into two groups. The children bring a picnic lunch and spend the day under the guidance of trained leaders, with mothers helping as volunteers. Hikes, excursions, water sports, story telling, and dramatics fill the hours. Headquarters again is the Day home, its spacious lawns and nearby woods offering shady spots to play and ample room to explore.

Learning to know one another

The play school, too, is a laboratory of adventure and exploration in human relationships. It offers an opportunity for children to find out about one another. A story hour, for instance, may be taken over by a Chinese mother who tells the children stories of China. A Polish or a Negro mother may sing the songs of her people.

Recently it was realized that grandfathers, often neglected, have something to add to the understanding of children. One grandfather, who had been a woolen manufacturer before he retired, was invited to tell a story of how cloth was manufactured in an earlier time. He constructed a miniature loom, which he used to illustrate his story. Thus grandpa became a person of new importance to the youngsters, and a bond between the old and the young was established.

One visiting the New Haven project naturally asks:

"What kind of difficulties have you met and how do you overcome them?" For of course, in any effort to bring people of different races together you must expect difficulties.

"The way we have gone about this," says the director of the project, "has been to start on a small scale, getting the endorsement of a few key people who will give moral support. We try to anticipate difficulties and find a way around them and we are content to go slowly. We find it takes about a year for a sound project to mature into action."

Although the New Haven project receives a subsidy of $5,000 a year from the National Conference of Christians and Jews for the 2 years the sponsorship lasts, money is also secured from local sources. This year the funds amounted to $7,500. Individual memberships in the project bring in $1,000. Fees paid to the nursery school, varying for the different schools, the price being set by the parents themselves, also bring in some revenue. Various local organizations find ways to raise money. The American Veterans Committee, for instance, through a newspaper drive and other means, raised $1,000.

Closing the nursery-school season this year, a carnival was held to raise funds. More than a hundred persons worked like beavers in the preparation. It proved a spectacular success, brought out more than 1,200 parents and children, was packed with fun, and netted $600. It was unanimously agreed to make the carnival an annual affair.

Not long ago a real-estate dealer in the vicinity of one of the project's centers, who had long held out against sales or rentals to members of one of the minority groups, sold a house to a family in such a group. Asked why he changed his policy he answered: "No use hanging on to that attitude with a place like this in the neighborhood."

The project serves as a kind of visual aid in the community. In several neighborhoods where activities are carried on, institutions have changed their policy and opened their doors to those who

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Story hour is a lot of fun at the summer play school of New Haven's neighborhood project.

In Birmingham, England, this type of bassinet is used for premature babies. It has a washable lining, with three pockets for hot-water bottles, one at each side and one at the foot.

BRITISH EXPERIENCE IN THE CARE OF THE PREMATURE BABY

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ENGLAND'S first hospital unit for babies born prematurely in their own homes was opened 17 years ago in the City of Birmingham Maternity Hospitals.

For the first 13 years after that, provision in the country as a whole of such special accommodation for premature babies increased slowly.

But in 1944, the Ministry of Health issued a circular to all welfare authorities, recommending that they provide facilities for care of premature babies, both in hospitals and in their own homes, and this circular has stimulated a great deal of interest in such babies.

Most welfare authorities have carried out the Ministry's recommendations concerning home care, but lack of building facilities has held up many programs. Efforts have been made, however, to set up units in existing hospitals, such as the unit described in this paper.

The need for special care of premature babies is as great in Britain as it is in the United States. In Birmingham, England, 6 percent of all the babies born alive are prematurely born (that is, they weigh 5½ pounds or less at birth).

Prematurity accounts for approximately three-fifths of the deaths of infants during their first 4 weeks of life, and one-third of the deaths up to the end of the first year.

The Ministry of Health circular suggests that for every infant weighing 5½ pounds or less at birth the weight should be recorded on his birth-notification card, and as a result country-wide figures for the incidence and mortality of premature babies will soon be available.

What causes prematurity?

Various investigations have been carried out recently in Britain in order to discover the causes of the premature births. These are most conveniently divided into known and unknown causes.

Known causes.—In different investigations, maternal ill-health was reported for 32 to 48 percent of the premature babies, toxemia being the greatest single cause of prematurity. It was found that in 12 to 16 percent of the cases the pregnancy was multiple. Fetal deformity occurred in 3.4 to 5.9 percent of the premature babies studied.

Unknown causes.—In the previously mentioned investigations no cause for the onset of premature labor was determined in 32 to 51 percent of the cases.

More attention is now being given to the effect of social conditions on prematurity; and Prof. Dugald Baird has demonstrated three important facts concerning premature infants born in Aberdeen:

(1) The incidence of prematurity is twice as high among the poorer people as among the richer.

(2) Among the poorer people, over 50 percent of the prematurity is unexplained; among the richer, a very small percentage.

(3) Proportionally more of the smaller premature babies are born to the poorer people.

(4) Among the poorer people the premature babies in every weight group have higher mortality than among the richer. In other words, premature babies born of poor mothers have a lower vitality.

An experiment carried out by the Peoples' League of Health showed that an adequate diet during pregnancy can reduce the incidence of prematurity.

What causes death in the premature baby?

Among premature babies in Great Britain the principal causes of death in the first month of life are: (1) Prematurity, (2) intracranial birth injury, (3) infection, and (4) fetal deformity.

In Birmingham, a premature baby is 22 times as likely to die during the first 4 weeks of life as a baby weighing over 5½ pounds at birth, and the risks of death from infection and from birth injury are each nine times as great for prematures as for other babies.

The risk of death between the ages of 4 weeks and 1 year is approximately twice as great for premature babies as for other babies, and it is interesting to find that the increased risk of death from infection still exists after the first 4 weeks of life; it is more than twice that for babies that are not premature.

How can we reduce mortality due to prematurity?

As steps toward reducing the high mortality due to prematurity, efforts are now being made to reduce the incidence of premature birth by improving social conditions, ensuring an adequate diet during pregnancy, improving prenatal care, and providing more hospital beds for pregnant women with complications likely to lead to premature labor.

In addition, efforts are being made to reduce the mortality among premature babies by ensuring better care for them during and after delivery.

A program including all these efforts has been in effect in Birmingham for a number of years, and the deaths among all premature babies in the city during the first 4 weeks of life were reduced from 26 percent in 1938 to 18 percent in 1946; the deaths among such babies in the first year of life were reduced from 34 percent to 23 percent.

These figures can be still further reduced, as is shown by the results obtained in the City of Birmingham Maternity Hospitals, to which the premature-baby unit described in this paper is attached. In 1946 the incidence of prematurity in this hospital was 8.5 percent, and the neonatal mortality among the 188 premature babies born there was 10.1 percent.

When Birmingham's premature-baby unit was opened, in 1931, it consisted of one large nursery for 10 infants and 6 single rooms for mothers. It soon became obvious that smaller nurseries, and more of them, were required.

Thereupon the large nursery was divided into two smaller nurseries, and some of the single rooms were also used as nurseries. This, however, limited the accommodation for mothers and therefore lowered the incidence of breast feeding.

Recently it was decided to take over the second floor of the building, and the unit will now accommodate 26 babies and 8 mothers.

The first floor consists of two warm nurseries, four cool nurseries, two isolation nurseries, a milk room, a ward kitchen, utility rooms, and a nurses' toilet.

The second floor consists of eight small wards (each for one mother and baby), a demonstration room, a day room for the mothers, a ward kitchen, a utility room, a bedpan room, and a bath and toilet for the mothers.

All nurseries are entered from a central corridor, where the nurses and doctors put on masks and gowns and wash their hands.

Traffic into the nurseries is strictly controlled. The only persons who enter are the nurse on duty in each nursery, the nursing superintendent of the unit, the senior medical officer, and the pediatric resident physician. Visiting doctors, nurses, medical students, and so forth, are only allowed to observe the nurseries from the corridor.

The smallest infants, requiring the most individual care, are placed in a nursery with four bassinets, as four is believed to be the maximum number of such infants that can be cared for by one nurse per shift.

The somewhat larger infants (under 4½ pounds, but not requiring so much individual care as the smallest ones) are placed in a nursery with six bassinets, as one nurse per shift is able to care for this number.

As there are no cubicles in these nurseries, a floor area of 50 square feet is allowed for each bassinet, and the bassinets are placed 6 feet apart. This arrangement has proved most successful in preventing spread of droplet infection from one baby to another.

The two warm nurseries are kept at a temperature of 70° to 75° F. Higher temperatures are avoided because of the bad effect on the staff. (English doctors and nurses are not accustomed to the high temperatures commonly found in America.)

Luckily, experience has shown that even the smallest babies thrive well in a nursery kept at this temperature, provided the bassinets are heated. The nursery temperature becomes detrimental to the smaller babies only when it falls below 70° F. We have found that babies over 4½ pounds usually do better in a temperature of 65° F. after the first few days of life.

Each of the four cool nurseries on the first floor accommodates two bassinets. These nurseries are kept at 60° to 65° F., according to the need of the infants. Two isolation nurseries accommodate two cots each, and these nurseries can be kept at any temperature or humidity desired.

The eight wards on the second floor are kept at 60° to 65° F. A baby is only transferred to his mother's room when he is sufficiently well developed to cope with the relatively cool atmosphere and when he is able to feed from the mother's breast.

The provision of accommodation for breast-feeding mothers has proved an important factor in promotion of breast feeding.

Heating the nurseries

All nurseries are heated by hot-water radiators and gas fires. Natural means of ventilation are used (windows and ventilators) and the required humidity is obtained by heating pans of water on gas rings.

The relative humidity in the warm nurseries is 60 to 65 percent; it is measured by wet- and dry-bulb thermometers provided in each nursery.

No air-conditioning plant has been installed because the unit is a training school for nurses who will go into homes to care for premature babies, and it is important to teach these nurses how to obtain the necessary conditions by simple means available in an ordinary English home.

Each nursery has a lavatory for hand washing, a diaper can with a lid, and a receptacle for soiled linen.

Each bassinet has a locker containing toilet articles and a thermometer, also a shelf for the nurse's gown.

The milk room is equipped for sterilization of bottles and preparation and sterilization of breast milk and milk mixtures. Nurses enter this room only if they are wearing cap, gown, and mask.

The kitchen on the first floor is chiefly for the use of the staff, but it is also available for washing used bottles and nipples, so as to avoid taking soiled utensils into the clean milk room. The kitchen on the second floor is for the use of the mothers.

A large utility room on the first floor contains a small electric sterilizer for instruments, small bowls, and receivers, and a large sterilizer for the bathing bowls. (Bathing bowls are used for the larger and older infants, to avoid the use of common baths.) A smaller utility room on the same floor is used for collection of diaper cans until they are removed from the unit. A utility room on the second floor is used for sterilizing.

A day room is provided for mothers who are up and about. A mother is accepted for admission when her infant is 3 days old, after the period of greatest mortality is over and the infant is likely to survive.

Mothers usually remain in the unit for 3 weeks; they then return home and come to the hospital daily to supply breast milk. As soon as the baby is strong enough to suck, the mother breast-feeds him once a day.

A demonstration room is provided for the use of mothers who are living at home and coming to the unit each day for the purpose of breast feeding. In addition, this room is used to teach mothers how to care for their babies before the babies are sent home.

Babies are brought to the unit by the city ambulance service, in special baskets, each heated by three hot-water bottles. These baskets are kept at the ambulance station.

Each time an infant is brought to the unit in one of these baskets, a clean basket is handed to the ambulance nurse in exchange, thus ensuring a supply of clean baskets at the ambulance station.

The ambulance nurse is provided with a flashlight so that she can watch the baby's color. A mucus catheter is available, and also a supply of oxygen, which is given by means of a rubber mask.

On arrival at the unit, the baby is admitted to a warm nursery, if newly born and free from exposure to infection. If he is admitted later than a few hours after birth, or if he has been exposed to infection, the baby is placed in an isolation nursery until proved to be free from infection.

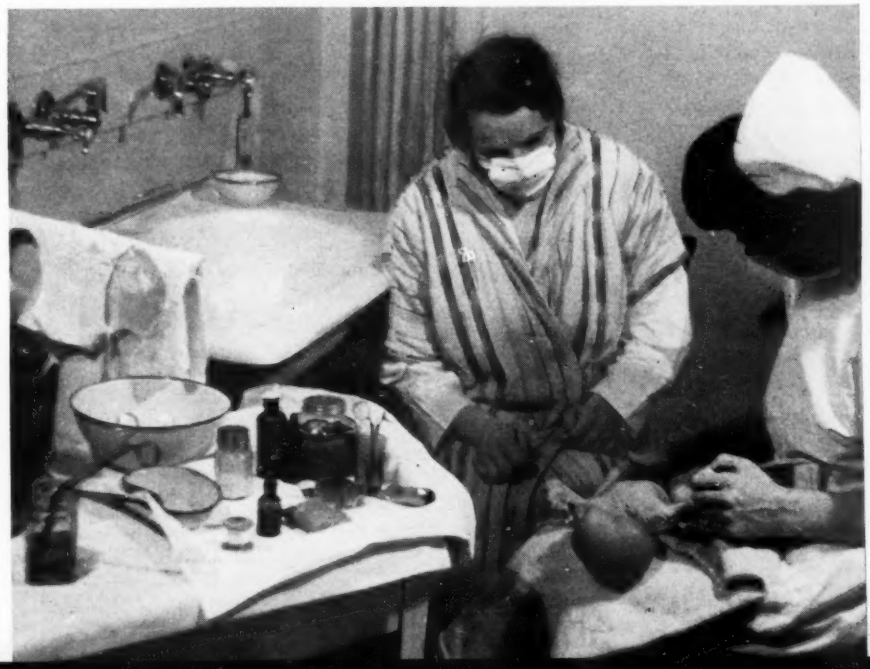
On admission, the baby's general condition is noted, his rectal temperature taken, and the cord inspected for bleeding. The infant is then transferred to a heated bassinet and allowed to remain undisturbed (except for emergency treatment, such as suction to remove mucus from his throat, or administration of oxygen) until he has recovered from his journey. Weighing and dressing are delayed until the condition of the child warrants the handling involved.

The resident physician examines each baby for signs of abnormality or disease as soon as possible after admission. During this examination, the child remains in the bassinet and is handled and exposed as little as possible. Vitamin K (2 milligrams) is given routinely to each baby.

Up to the present time no incubators have been used. Open bassinets, with three hot-water bottles, are used for even the smaller infants. Each bassinet is fitted with a washable lining, in which there are three pockets, for hot-water bottles, one at each side and one at the foot.

For a small baby, additional heat is supplied by means of an electric pad placed under him. To prevent contamination of the pad, or electric shock, or overheating of the baby, the pad is covered by two layers of rubber sheeting, separated by four layers of blanket. The hot-water bottles are changed, in rotation, every hour, in order to keep the heat of the bassinet as uniform as possible.

This mother in Birmingham, England, is being taught by a nurse in the maternity hospital how to take care of her premature baby. Before the baby is discharged from the hospital, a public-health nurse will visit the family home to be sure that everything is ready to receive him.



Thermometers inspected regularly

Each heated bassinet is provided with a thermometer, which is placed between the blankets on top of the baby. This thermometer should never rise above 95° F. if overheating is to be avoided. Each electric pad is provided with a red "tell-tale" light, which reminds the nurse at regular intervals to inspect the thermometer.

The baby's clothing is made of "union flannel" (wool with a small percentage of cotton to prevent shrinkage). A set of clothing consists of a vest, a hooded gown, a diaper, and a bib. As the air in the nurseries is relatively cool, the baby's loss of heat from his head may be considerable unless the head is covered, and, for very small babies, head shawls are used in addition to the hooded gowns.

In the rather cool English nurseries, it is important to avoid unnecessary exposure during such nursery procedures as changing the diaper or the clothes, oiling, and temperature taking. The smaller babies are cleaned with oil. A soap-and-water bath is not given until a weight of 4 pounds is reached.

In healthy babies, the rectal temperature is taken twice daily and it is allowed to stabilize between 96° F. and 99° F.; the smaller the baby, the lower the level of stabilization within this range.

The baby is kept lying on his side (on the right side after feedings and on the left side between times) because of the danger of his regurgitating food and inhaling it. The smaller the baby, the less he is handled; and any necessary handling takes place before a feeding, not after.

Oxygen is given by means of a soft rubber face mask. Nasal catheters are avoided because of the danger of injury to the baby's nasal membrane and the possibility of subsequent infection.

Feedings are started after 12 to 24

hours of life. At first small amounts are given; these are gradually increased until, at the age of 7 days, the baby is receiving daily 2 ounces per pound of body weight, and at 14 days, 3 ounces per pound of body weight. At this latter time the daily caloric value of the food is usually 50 to 60 per pound of body weight.

Breast milk is used whenever possible, the protein content being increased by the addition of 1-percent or 2-percent hydrolyzed casein. If breast milk is not available, evaporated milk is used, in increasing strengths from 1 to 12 to 1 to 5, with 1-percent or 2-percent added hydrolyzed casein and added sugar.

Babies not strong enough to be put to the breast are fed by bottle if they can suck well. A medicine dropper is used if the baby sucks poorly but can swallow, and for babies with poor swallowing ability feedings are given by stomach tube. The baby is fed every 2 hours until he can take a sufficient amount at each feeding to be fed only every 3 hours.

Administration of vitamins B and C is commenced on the third day, and of A and D on the seventh day. A preparation containing calcium and phosphorus is started on the fourteenth day because of the low mineral content of breast milk and the relatively great requirements of the premature baby. Administration of iron is begun at 4 to 6 weeks.

To prevent infection

Measures for prevention of infection, such as limiting the number of bassinets in each nursery, spacing of bassinets, free ventilation, and limitation of traffic into the nursery, have already been mentioned.

Parents are allowed to see their babies from the corridor through viewing windows. Other relatives and friends are not allowed to visit.

The members of the staff are medically examined before being allowed to take up duty in the unit and must report if sick.

Absorbent and impervious masks are used by everyone working in the unit, including the mothers when feeding or caring for their infants and the workers who clean the floors of the nurseries.

Floors are treated with oil to reduce the risk of dust-borne infection.

Direct infection is prevented by the use of gowns, by careful hand washing, by care with laundry and in preparation of feedings, and by providing individual equipment for each baby. Bedside care has replaced the use of common changing tables, and sterilized bowls have replaced the common bath. All pieces of necessary common equipment, such as stethoscopes and measuring tapes, are carefully sterilized before use, and weighing scales are draped with a fresh piece of paper for each baby.

Any baby showing the slightest sign of infection is immediately removed to an isolation nursery, and no new baby is admitted to the affected nursery until the nursery has been proved free from infection.

The nurse responsible for preparation of feedings is never allowed to undertake duties that involve changing of diapers. With this one exception "task-nursing" is not favored; in fact, one nurse is responsible for the complete care of all babies in her nursery, and she does not enter other nurseries.

The senior medical officer in charge of the unit visits it twice weekly, seeing each baby and discussing current problems, and she is also available day and night for consultation. This medical officer is responsible for the plan of care, which is available in writing for the use of the medical and nursing staff.

In addition, the pediatric resident physician visits the unit daily, examines each infant on admission and before discharge, and is available day and night for emergency calls.

Before a baby is discharged, his home is visited by a public-health nurse, to ensure that everything is ready for him. In addition, his mother is given demonstrations on the care of her baby (bathing, dressing, handling, preparation and giving of feedings, protection from infection, and so forth) before he is sent home.

Arrangements are made for the baby to be taken to the special "small baby" session at the well-baby clinic, and to return to the unit for special follow-up examinations at stated intervals.

The unit is recognized by the Ministry of Health as a training center for nurses in the care of the premature baby.

Medical students from the University of Birmingham are given demonstrations in the unit and many postgraduate courses for doctors, nurse-midwives, public-health nurses, and so forth, are held at the unit.

Many aspects of prematurity are being studied in the unit; for example, the effects of high-protein feeding, the incidence of rickets, the prevention of anemia, and the rate of mental and physical development of the baby. It is of interest that retrolental fibroplasia has not occurred in the Birmingham premature babies.

Hospital care is obviously best for premature babies with poor homes. It is also best for all those weighing less than 4½ pounds at birth, because these small babies are likely to regurgitate food and inhale it and so require a whole-time nursing service. But results can be very satisfactory for the larger babies treated in good homes, with good equipment and a good nurse. In some parts of England no special hospital accommodation is available for premature babies, and home care becomes important.

When the baby goes home

Recommendations in the Ministry of Health circular for home care are:

A separate room for the mother and baby, provision of equipment on loan by the local health authority, a supply of expressed breast milk when necessary, the advice of a pediatrician, and the services of a homemaker to care for the family while the mother is unable to do it herself.

Nurse-midwives and public-health nurses with special training and experience in the care of premature infants are recommended as suitable persons to give attention to premature infants born at home.

The suggested equipment for loan includes a bassinet, clothing, hot-water bottles, an electric pad, a feeding bottle, a thermometer, and a mucus catheter. It is doubtful, however, whether an electric pad should be included, because of its possible dangers, especially from overheating, when in unskilled hands.

In Britain we realize that reduction of mortality due to prematurity can only be achieved if there is full realization of the dangers associated with prematurity and if full cooperation exists between the hospital staff and the home attendants. This entails special education of the various persons concerned.

Reprints available in about 3 weeks

WE NEED FACTS IN PSYCHIATRY

LESLIE B. HOHMAN, M. D., *Professor of Neuropsychiatry, Duke University School of Medicine, Durham, N. C.*

IN this looking forward which you have asked me as a representative of psychiatry and medical mental hygiene to do, perhaps you have chosen someone with too little faith. I can foresee no immediate fulfillment of the hopes of a yearning world for the miraculous solution of our emotional problems. Psychiatry has probably sold mental hygiene too well and perhaps too early.

Troubled people have grasped eagerly at the chance to see the promised land. Our psychiatric enthusiasm to show them the green pastures has pushed us with the running steps of speculation and theorizing instead of the painstaking plodding of fact-finding and experimental evidence. It may be excusable, if psychiatry has let its enthusiasm run beyond its capacity to produce a promised body of sound facts and effective workable methods.

If I appear to you as a pedestrian instead of a winged fleet-footed Mercury, I can only plead the evidence of the history of successful medical progress. Preventive medicine has become possible only when we have learned the causes of disease. The successful treatment of physical disease has only been possible after painstaking and painfully slow research and investigation.

Psychiatry today knows extraordinarily little more about the cause of the major mental diseases than it did 50 years ago. It has produced a wealth of theories, but a paucity of facts.

More knowledge required

The violent debates of the protagonistic psychiatric theorists bespeak their lack of facts. The rest of medicine can show a united front because there are larger areas where investigative research has led to logical, irrefutable knowledge. That united front will come to still the babel of voices when psychiatry has comparable knowledge.

Psychiatry and mental health have only just begun to take the pathway of scientific research and investigation. Here and there one sees the beginnings of the quest for real, basic facts and the desire and willingness to subject theory to experimental investigation.

Looking at our hurried false starts should not blind us to the very significant contribution which psychiatry and the mental-health movement have made in this period of their enthusiastic infancy. They have brilliantly centered interest on the study of personality and personality structure.

Although the psychopathology of mental disease is only hypothetically understood, the study of its manifestations have brought into the focus of attention many phases of normal psychology which were dimly lighted before.

Light from different sources

Our studies of the abnormal mind have made possible a dramatic presentation of many facts that must surely have their representation in normal psychology.

We have called upon our young sister sciences of cultural anthropology and sociology to aid us in the proof of this thesis. Furthermore, our hypothesis that psychologic facts do profoundly change personality structure and personality response has been proven for us through investigation by the cultural anthropologists.

Given at the National Conference on Family Life, Washington, D. C., May 6–8, 1948.

I fear that educators and social scientists have been so swept by our promises and our theoretical constructs that they are little more than blind, enthusiastic followers of psychiatrists. Not all try to follow the same theories—there are enthusiastic followers of all psychiatric camps—but they are all trying to put into corrective practice in the normal what the various schools of psychiatry have said was wrong with personality.

Again, like Cassandra, I moan, if only we could guide them with an established body of proven, sound data!

We must, I am convinced, undertake in the near future many long-range, painstaking studies.

We must try to get answers

1. We need investigative research to instruct us whether we are right in thinking that healthy emotional maturity and balance may be achieved by the present fashionable permissive attitudes or whether directive attitudes in education, especially of the emotions and emotional attitudes, will produce the type of emotional balance we need.

2. We must be able to answer with evidence the question whether human psychologic healthy development is governed, as one theory insists, only by the avoidance of so-called anxiety or conflict; or whether according to another theory it takes place by a more vital dynamic emergence of positive and trainable drives and action patterns.

The answers to such questions are vital and at the core of our problem of mental health.

That we can influence personality structure by environmental circumstance is established, but that is far

from knowing when and how it can be altered.

3. We must be able to answer many fundamental questions about the relative importance and influence of early life experience on final personality structure and reaction.

Are we right about the time element?

Perhaps future investigation may show that the later unfolding of latent patterns of behavior may play as decisive a role in personality structure as infancy and early-childhood influences. There is some evidence that this hypothesis of later unfolding may be even more important. This is clearly open to investigation and should be investigated in animals as well as human beings.

4. We need to know if mass cultural impacts on youth, such as those produced by the Nazification of German children are lasting and permanent—or are they modifiable?

5. We need to know whether the similar although not deliberately planned cultural impacts in these United States of increasingly more constricted housing, enlarged cities with more and faster automobiles, more and more out-of-the-home meetings of youth are permanently destructive of family life or whether they are capable of modification and resynthesis.

6. What impact will our expanding of the school period from very early childhood to very late adolescence have upon the family and its importance in the life story of our people? Will this strengthen or weaken the home and family?

7. Is the purpose of our present emphasis on the importance of love and security attainable in a system where less and less of the education and recreation of children and young people takes place within the family structure? Can we substitute qualitative for quantitative participation in family living and still maintain the valuable influences of the family? If so, how can we develop techniques for this new kind of concentrated family influence?

8. Will mental health be increased or decreased by decreasing or increasing the family strength? Again I say, we do not know. Cold, hard facts and investigation alone can give the answers.

Of one thing we can be certain. The ignorance of blind conviction or even noble prejudices will not give the answers. Psychiatry as such will always of necessity be concerned primarily with psychopathology. The study of disease can point the way to the study of health, but ultimately it will be the study of normal growth and development that will produce the techniques for healthy living.

I believe that an experimental sociology, an experimental, cultural anthropology, and an experimental individual psychology offer most of our hopes for the future of the development of mental health.

Psychiatry, with its study of the abnormal, will be an increasingly valuable helper, a stimulator, and a corrector. It must develop positive, factual, and experimental investigation to fortify itself in the scientific investigation and interest in human mental health which it has started.

Psychiatry is started in its scientific, investigative attitude but it can only do its rightful job if the Nation furnishes it with facilities for investigation and enough money to attract a growing group of young investigators.

Mental health calls for wider extension of counseling services in schools and in the community.

What can we do at once?

As I see it, the *immediate* contributions that mental hygiene can offer are:

1. Increasing use of group discussions for parents and children. It has high hope of objectifying tensions and problems.

2. Increasing use of sex education—for facts and attitudes.

3. Training of youth for parenthood by practical, thorough courses in child training, with the use of actual nursery schools in high schools.

4. Wide extension of counseling services in schools and in the community.

5. Public discussion by radio, magazines, newspapers, and group discussions, as well as school education, to try to break up paranoid belief systems—political, social, economic—which so disrupt our community solidarity.

6. Frank facing of the possibilities of war and the use of training for both possibilities—peace and war.

7. Extension of mental-hygiene clinic facilities to all areas of these United States, to aid in diagnosis and prescription for treatment; to make evident the need for more facilities for better special education and techniques; and the great extension of boarding-home facilities—to salvage children when the home has failed.

Reprints available in about 3 weeks

UPHOLD RIGHTS OF PARENT AND CHILD

INEZ M. BAKER, *Parish Supervisor, Children's Division, Orleans Parish Department of Public Welfare, Louisiana*

PARENTS and children should, of course, have the opportunity to remain together if they have the *will* and a reasonable possibility to do so. However, as long as society is subject to its present ills, some children will have to be cared for by other than their natural parents, and children's agencies will try to place them in foster care—in a family home or in one of the many forms of group or institutional care.

The type of placement determines in some measure what rights and responsibilities the parent retains or relinquishes when separated from the child. The very nature of placement service is such that the rights of the individuals affected can easily be violated unless the agency that provides the service, as well as the citizens who support it, are aware both of the nature of separation and placement and the rights that may be threatened.

Let us first look at the purpose of the children's agency. It has no legal authority, unless the law specifically grants this. The agency's purpose is to serve individuals—parents and children.

It is parents who first come to the agency, hoping that solution of their problem lies in placement of the children. The problem may result from illegitimate pregnancy, physical or mental illness of one parent, desertion, separation, or other conditions. More often than not it mirrors a combination of subtle and complicated factors—marital difficulty, rejection of children, immaturity of parents, and inability to accept parental responsibilities.

Whatever impels a parent to seek placement of his children, he has a right to know what placement will mean to him and his children. The agency has a responsibility to help him consider what both must give up, as well as what both may gain.

And indeed any parent who places a child does give up a great deal. He cannot see to the child's day-by-day care and all that goes into it. He has no control of the child's activities, his friendships, or the affectional ties that may develop. He must comply with rules on visiting and on payments for board, and he is limited regarding the gifts and recreation he may provide. Such deprivations are inherent in separation and successful placement.

Then there are rights that a parent must not be denied except by a court of proper jurisdiction—the right to see his child, to provide financial support, and to terminate the placement when he sees fit.

Many questions arise

Besides these tangible matters, there are subtle ones, even more serious. Does the parent know how he will feel about having his children cared for by someone else? Does he feel that in placing his children he advertises to the world his failure as a parent? What about his feeling of worthlessness? Does he know that his children may on the one hand despise him for what he has done, and on the other feel that they are "bad" and unworthy of the love of even their own parents? Does he know that his children may resist foster care in unspoken ways, ranging from wetting the bed to stealing? Is he prepared to work with the agency down the long and rocky road to happy, successful placement?

Parents and children have a right to know what is involved. They have a right to expect help and understanding in thinking through their conflicts about this all-important decision, just as they have a right to expect help in supporting the child in foster care if this is decided upon.

Condensed from paper given at Louisiana State Conference of Social Welfare, Baton Rouge, March 1948.

Furthermore, the agency can fulfill its purpose of serving parents and children only if it recognizes the right of the parent to decide whether or not placement is a desirable solution to his problem. This means that the parent makes his decision to place or not to place, without pressure, threats, or persuasion by the worker. So long as the parent has full custody of his child, the decision rests with him, not with the agency. He has a right to decide what is best for him and his children unless the right is legally denied him. In a democracy that right can be denied only by a court of competent jurisdiction.

Yet parents are sometimes denied the opportunity to make this decision. We social workers sometimes stress the advantage of placement, hoping that we can keep the parent satisfied with an arrangement he does not understand and which is not really his. It is beside the point to say that such placements are doomed to failure.

We must not deny parental rights

To assume that we know best is to take liberties with the complicated relationships between children and parents. This not only denies parental rights but is contrary to the agency's duty to provide services that parents are free to utilize or reject so long as their legal authority concerning their children remains intact.

To reiterate, the responsibility for the decision to place or not to place rests with the parent as long as he has his full legal rights concerning his child. The responsibility of the children's agency is to help the parent come to a decision that is right for him and his child and to help him live with his own feelings. This implies acceptance on the part of the agency of the client's decision and his feelings about it. It is very different, and requires more skill

and self-discipline than making a decision for the client according to what the worker may consider desirable. So long as the right to make the decision rests with the parent, the agency must respect that right.

Recognition of the right of parents to make decisions in behalf of their children does not in any way deny the responsibility of the agency. This is to apply case-work skills in helping parents to see what alternatives are open to them and where these alternatives may lead. It is to help the parents recognize, understand, and indeed live with their mixed feelings about caring for or placing their children. This responsibility is also binding on the agency after placement. These responsibilities are important, for few if any parents, regardless of how derelict they may be in their parental roles, are totally without feeling or concern for their children.

So far as we have considered the problem of parents whose legal authority concerning their children is not in question. For these parents, who voluntarily seek help with respect to their children, the agency's part is to provide case-work service, which may include placement if parents and agency agree upon it. When they agree upon a plan for care, the agency must take responsibility for its soundness and success.

This does not mean, however, that the agency passes judgment on plans of which it is not a part. If a parent decides to place a child with Great-aunt Susie, a plan that the worker believes is of questionable value for the child, the worker's role goes no further than to help the parent think through what may be involved in the plan. The agency would not be part of the arrangement with Great-aunt Susie, nor take responsibility for it.

Every client deserves our respect

The fact that a parent brings his problem to an agency does not give the agency authority or license to determine the course of a child's life. So long as parental plans are within the law, the agency has no more right to say where children shall live than to say where they shall go to school, or whether or not they shall have their teeth straightened.

If I labor the point that children's agencies do not have the authority or function to control the lives of children whose parents voluntarily bring their troubles to an agency, it is because of the widespread misconception in this area. Furthermore, if we are clear on the rights of parents who retain full authority over their children, I think we can see more clearly the rights of parents and the responsibility of agencies when a court steps in to alter the natural status of parents and children. Here I should like to consider both families where parental rights are in question and those in which legal action has already restricted or transferred certain parental rights.

Space does not permit full discussion of the so-called "protective" function sometimes assumed by children's agencies. In brief, we might say that families affected by this rather undefined function are those in which the right of the parents to retain full responsibility for their children is questioned, at least by some part of the community, though legal action may not have been taken. Perhaps it is with regard to this group more than any other that we see misunderstanding of the rights of parents and children and of the purpose of children's agencies.

For example, there is Mrs. B., who calls up an agency demanding that a worker come and get the J. children next door and place them in an institution or foster home. Her reason may be almost anything, ranging from the children's being left alone without food to their pulling up the plants Mrs. B. has just set out. The important thing is that Mrs. B. disapproves of the way the J. children are being reared; she thinks they can never become "decent citizens," so there must be "a law against it." The children's agency, for which she pays taxes, or to which she contributes through the Community Chest, must have authority to enforce *her* will to do something about the situation.

Then Mrs. S. calls up. She is indignant about the drinking and immoral behavior of Miss W. The agency had placed Miss W.'s baby, born out of wedlock, and Mrs. S. feels that the agency is encouraging immorality by relieving Miss W. of her responsibility. The proper treatment for Miss W., says Mrs. S., is a good jail sentence to teach her a lesson, and close supervision thereafter by the agency to see that she takes care of her child.

The Mrs. B.'s and Mrs. S.'s, however, are usually reasonable people. When they realize what their request involves, they are horrified, for they would not wish to live in a society where parents' rights could be taken away without due process of law.

To the extent that we, as social workers, are clear on the rights of parents, and the purpose of our agencies, we can hope the Mrs. B.'s and the Mrs. S.'s will direct their energies into more productive channels. And let us not forget that Mrs. B. and Mrs. S. are as much our

Parent and child should be together if they have the will and a reasonable possibility of it.

clients when they bring us these problems as if they brought us problems concerning their own children. They have the same right to our respect and understanding about the implications of their requests.

All citizens, and particularly social workers, should have a sense of responsibility for the well-being of all children. We know that there will always be some parents who misuse their parental rights, just as there will always be some individuals who violate the rights of others. And society must protect itself by placing limitations on the individual who is unable to exercise his own rights without violating those of others. In a free society we delegate to the courts the duty of making the decision as to whether certain of an individual's rights shall be limited, or removed, in the broader interests of society. It cannot be different with parental rights.

Public opinion rules

We have in this country some vague idea of a level of care and opportunity for children that should be the minimum, and this is translated into law with varying degrees of definiteness. The level is interpreted differently in different communities, in different economic strata, and in different races. And I suspect that in a given community it represents pretty generally what the majority of the people in that community want.

And so the Mrs. B.'s and Mrs. S.'s have a right to take situations to court when they feel that children are denied what they consider a minimum of opportunity. We should hope that the community could provide services to enable the families in question to meet the minimum needs of their children if they have the desire and ability to do so. We should also hope that the agency that received such complaints would have a sufficiently careful screening process so that the agency will not intrude upon the family's right of privacy without justification. We should further hope there is general understanding throughout our citizenry that children's troubles are not over when a judge orders separation from their parents and that placement is not the answer for all children whose parents have difficulty in caring for them.

When a court of proper jurisdiction decides that parents have violated, or are unable to exercise, their right of care and control over their children, the court may transfer this right to an agency or an individual. This transfer of custody places with the agency the right and responsibility to determine, and provide the child with, a suitable living plan. The parent has a right to know where his child is, to visit him in accordance with established arrangements, and to maintain his relationship with him, unless specifically forbidden by a court. The latter restriction is rarely placed on parents except in spectacular situations where the child or the person caring for him is physically endangered. When a court removes the child from the parent's custody, the latter may not regain it except as restored by the court. However, the parent has the right at any time to request the court to consider the return of custody. The agency has no right to discourage a parent from making this request.

Before considering the agency's responsibility for helping parents and children whose natural status has been altered, it seems fitting that we as social workers examine our own feelings about courts and their authority.

If we, as social workers, recognize the court as the instrument of our society for dealing with misused rights of parents, then we should be able to use it as objectively as any other resource. If we honestly believe the rights of children are threatened, and we have been unsuccessful in helping parents, do we not have a responsibility to bring the matter to a court's attention?

Agency must be fair with parents

It seems to me that as social workers we have too often looked upon the court as a last resort. To use it was to admit failure. I fear we have at times assumed court authority ourselves in insisting that people do as *we* thought they should, by taking advantage of an emergency to place a child ourselves, and all but refusing to return him if we thought the parent might give improper care.

We have talked about losing our relationship with the client if we went to court. It has been my experience that in most such cases there is not much "relationship" to lose. Usually the worker has long since lost any possibility of a constructive relationship through her tenacious efforts to inveigle the parents into placing their child. Hence, by the time she gets to court, her own feelings are involved, and the parents' belief that going to court is a hostile act by the agency is not entirely unjustified.

I've been thinking a good deal during the last few years about courts, as have many other children's workers. I believe children's agencies have come a long way in making more objective use of the courts. But I fear that we still ask the court to agree with us and to force the parent to do what *we* think should be done.

It seems to me that our duty is to place the facts, as we see them, clearly and objectively before the court. To expect a court to accept our statement without also giving the parent an opportunity to do so is to deny the purpose of a court.

And above all, when it becomes our responsibility to bring a matter involving parents and children before a court, let us be fair. Do not parents have a right to know the step we are taking and the reason for it?

I am convinced that only if the worker is clear, first about parental rights, and secondly about her responsibility to her agency and her profession can she avoid the role of prosecuting attorney. When the worker has clarity, objectivity, and conviction about what she does, she can usually transmit her sincerity of purpose to parents; then there is a basis for working together. The parent may be angry and distressed, but a groundwork for respect and trust is laid.

Let me tell you about a mother, Mrs. M., to whom life has dealt heavy responsibilities, but few inner resources with which to meet them. Her children became the victims. A worker tried to help her; but she could take no definite step, either toward changing her situation within the home or planning for the children away from her.

The worker recognized Mrs. M.'s difficulties. She saw that the agency had not been able to give this mother the kind of help that would enable her to care for her children as the community expected them to be cared for. And in such situations it becomes the responsibility of a judge to make the decision.

So the worker reviewed with Mrs. M. what she would tell the judge—stating what the mother's difficulties were, and also what she had been unable to do for her children. Mrs. M.'s response was anger and despair. She would get a lawyer—would the agency have a lawyer?

The worker told her she had a right to have a lawyer if she wished; that it was not necessary in juvenile court, but that some parents find it helpful to have one. If she did not have the money she could ask the court to appoint one. The worker also explained that the agency did not have a lawyer in this kind of situation. And again she explained the basis on which the agency approached the court and the usual procedure in such a hearing, stressing that Mrs. M. would have an opportunity to tell the judge of the situation as she saw it, and that the worker would present it as it seemed to her. It would then be up to the judge. Mrs. M. responded, "I guess you have to do what *you* think is right."

In court Mrs. M. volunteered that she had decided not to ask for a lawyer. The agency had been fair, she added, so she guessed she could trust it. It would have to be up to the judge.

The judge did give custody of Mrs. M.'s children to the agency. However, the agency now has a basis for working with Mrs. M. and her children in a realistic way. Despite her feeling of frustration she has a degree of respect for the agency because it has been fair to her.

And this leads us to consideration of the agency's responsibility when parents' natural rights have been limited or denied by court action. The parent who has lost his legal control still retains certain rights—the right to see his child and maintain his relationship with him; the right to have the situation reconsidered by the court; the right to know he will not lose permanent custody through adoption. Parents and children also have a right to know what is involved in separation and placement, even though a court denies them the right to reject this service. The agency must respect these rights.

Perhaps the agency's most difficult responsibility is in the area of helping the child and the parent to understand what has happened and to handle their feelings about it. No less than in voluntary placement, the worker has a professional responsibility to help them meet their fears, anxiety, and distress. The fact that a court has stepped in does not minimize the agency's responsibility here, but unless the worker herself respects the authority of the court, she cannot fulfill this responsibility.

We must not omit the child's rights in placement. He has a right to a suitable living plan and to assistance in understanding and handling his feelings. In seeing that he is assured of these rights the worker needs to use professional knowledge and skill.

There is no justification for generalities—that the child needs love and affection and we will place him where he can get it, or that any home is better for him than his own. Except in the rarest cases of physical danger we might go so far as to say that *no* home is any better than his own unless he is able to use it. It is our responsibility to help him use it. We have sometimes leaned on sentimental platitudes and indulged in wishful thinking about children's need for emotional security. Scientific knowledge has stripped us of this kind of justification.

We know what separation means to children; that it is akin to death and carries with it anger, disillusionment, despair, and a deep sense of "badness." We know children handle these feelings differently, but that their usual defense is to deny the reality of, or necessity for, placement. Unless we can help the child to accept the necessity for placement, unless we can understand and accept his feelings about it, we can expect little better than an acting out of these feelings, or repression of them.

He will need help in adjusting to the unnatural state of having two mothers. Unless he can recognize his own feelings and get them off his chest, we may expect his energies to be directed toward gaining the love of his own parents, as symbolized by their taking him home. His fantasies will be engaged in an illusion of parental love. When this happens a child cannot put down his roots or benefit from placement. The potentialities for love and security in his new setting are of little consequence, for he is not ready or able to take them.

Our professional knowledge places upon us a responsibility we cannot escape. If a child is denied the right to live with his parents, be it through voluntary action of his parents, or court authority, surely he has a right to our help in handling the problems that separation has created for him.

In conclusion, we reaffirm the right of parents to make decisions in behalf of their children as long as they retain their legal rights.

The courts are the only instruments in our society with the authority to alter these rights. The role of the children's agency is one of service—not of passing judgment or exercising control, except insofar as control is transferred to the agency by voluntary action of the parents or by court authority. Parents and children have a right to the agency's help in understanding and handling their concerns about placement.

Children's agencies will be successful in discharging their responsibility for this help only if they are clear about the rights of parents and children and about the place and use of courts, and are skilled in their use of professional knowledge.

Then and only then can placement achieve its purpose as a service to parents and children.

Reprints available in about 3 weeks

CALENDAR

Aug. 23–27—International Congress on Population and World Resources in Relation to the Family. Cheltenham, England. Auspices of Family Relations Group of Great Britain.

Sept. 1–30—Youth Month. Sponsored by the National Conference on Prevention and Control of Juvenile Delinquency.

Sept. 4–6—American Occupational Therapy Association. New York, N. Y.

Sept. 7–11—American Psychological Association. Boston, Mass.

Sept. 13–17—American Dental Association. Eighty-ninth annual session. Chicago, Ill.

Sept. 13–17—American Association for the Advancement of Science. Centennial meeting. Washington, D. C.

Sept. 14–15—Children's Bureau Advisory Committee for Maternal and Child Health and Crippled Children's Services. Washington, D. C.

Sept. 20–23—American Hospital Association. Fiftieth anniversary convention. Atlantic City, N. J.

New Haven Project

(Continued from page 20)

before had been excluded. One church held a training institute for Sunday School teachers as a means of developing intergroup understanding in the church-school curriculum, with an anthropologist and a leading authority on preschool education taking part. The director of religious education of the National Conference of Christians and Jews, who is a member of the Yale Divinity School faculty, participated.

It would be difficult to measure how widespread are the effects of this cooperative community experiment. There are visible results which can be seen and weighed. From a small seed, planted by an individual in a single neighborhood, has resulted a series of community projects extending widely over the city. The project has attracted attention outside of New Haven, and the director is constantly called upon to explain the project to other communities. The intangible results of changing attitudes are less easy to measure. Many residents of New Haven, not sympathetic at the outset, have had a change of heart. The project has broken ground in a new field, requiring courage as well as sound procedure at every step of the way.

Many people ask: "Could such a project get under way without the personal drive of a Mrs. Day?"

Others who have studied the New Haven experiment answer that there are Mrs. Days to be found in many communities if a search for them is made. It is true that every such project begins with a fire of concern in the heart of an individual or group of persons. But often the fires smoulder and die for lack of the breeze of initiative to set them in action. More and more, however, people are finding ways to unite their concern in cooperative effort. This project in New Haven has proved that the neighborhood is a logical starting point of group activity to build better human relations.

Reprints available in about 3 weeks

"Building Today for Tomorrow in Our Neighborhoods," a manual by Gertrude Hart Day, which should be useful to other communities planning similar projects, can be obtained, by mid-September, from the National Conference of Christians and Jews, 381 Fourth Avenue, New York 16, N. Y., at 25 cents a copy.

IN THE NEWS

TO LAUNCH CHILD-SAFETY CAMPAIGN

In the hope of preventing some of the accidents that every year kill more than 20,000 boys and girls, a safety-education campaign will be launched early in September by the Metropolitan Life Insurance Co., with the cooperation of the American Academy of Pediatrics, the National Safety Council, and the Children's Bureau.

The campaign has two main objectives:

The first is to encourage parents, other adults, and older boys and girls responsible for the health and happiness of younger children

(a) to recognize the accident hazards confronting young children;

(b) to provide and maintain safe conditions for children in the home and at play; and

(c) to help children, through example and guidance, to develop safe practices.

The second objective is to encourage public-health, medical, and other interested agencies to give added emphasis to child safety in their own programs.

The slogan of the campaign is "Help Your Child to Safety." This is also the title of a booklet that is to be distributed to families as part of the campaign.

The booklet stresses not only the child's need for safe physical conditions in the home, but also his need to be free from undue worry or tension. "Often," it says, "a child's unhappiness or lack of self-confidence may be the underlying cause of a series of what appear to be simple mishaps. The child who is disturbed and unhappy may express his feelings unthinkingly in the form of hurts and injuries to himself."

Under the heading, "What Are You Doing to Help Your Child to Safety?" it asks the parents:

"Do you make safety a cooperative undertaking in your family?

"Do you have your child examined periodically by a doctor?

"Do you help your child to develop confidence in himself?

"Knowing children are great imitators, do you practice safety yourself at all times?

"Do you give your child sufficient opportunity to develop sound musuclar control?

"Do you help your child to learn the correct and therefore safe way of doing things?

"Have you made an inspection of your home recently to discover hazards, and have you taken steps to make your home as safe as possible?"

This campaign is in harmony with recommendations made by the National Health Assembly's maternal and child-health section. This group declared that accident prevention is as much a health problem as is prevention of disease. It also urged that research concerning accidents be undertaken, to make clear the real magnitude of the problem, to show what causes accidents, and to teach people how to prevent the large proportion of accidents that are preventable.

Similar emphasis was placed on child safety by the President of the United States in his Child Health Day Proclamation last year, when he called upon parents to dedicate themselves to the exercise of diligence toward prevention of accidents in the home, so that children may be protected from needless injury and suffering.

Plans of the program of the accident-prevention campaign are being sent to State and local health officers, State medical societies, school officials, nursing organizations, safety councils, and other groups and individuals interested in health.

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Pages 21 and 23, courtesy of the author, V. Mary Crosse, M. D., D. P. H.

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Page 28, Bernard Ravitz for Brooklyn Children's Aid Society.

Nations Join Hands for World Health

"In my country," one of the U.S.S.R. delegates said to me at the closing session of the first World Health Assembly, "we have a proverb that says, 'Two mountains cannot come together, but two men can.'"

Not two men, but several hundred men and women, representing 54 member nations of the World Health Organization, had come together in Geneva, Switzerland.

Their purpose was to hew out a common roadway ahead, along which the world's health workers and its medical resources might carry the hope of better health to the people of the earth.

For more than a month, the delegates had worked together. We had threshed out, and come to agreement on, many difficult questions. We would return, now, to our own countries. But each of us could carry back with us, not only the new road map of the World Health Organization but the lift of spirit that come when people agree to act together on common problems.

Wherever there are people there are health problems. As you sit in an international conference such as this, and hear the recital of these problems, it takes cool and dispassionate judgment to arrive at a decision how an international organization should go about helping people to better health. To health workers, all health problems have an urgency. But budgets have a way of making you balance urgencies against realities.

The World Health Organization has a total budget of $5,000,000 for 1949. Member nations will contribute to this budget on the same basis as they contribute to the budget of the United Nations. The United States meets 39 percent of the expenses of the UN. Our contribution to the WHO in the coming year, by act of Congress, is $1,920,000. On this basis, the WHO anticipates a budget of $5,000,000—the balance being made up by other member nations.

But even $5,000,000 can give a good push to the WHO caravan as it starts its health-bringing pilgrimage to the people who most need its help.

The World Health Assembly mapped out six jobs to which the WHO should give top priority in the year ahead. The first was control of malaria . . . The third and fourth were control of tuberculosis and venereal diseases. The fifth was promotion of better nutrition. The sixth was improvement of environmental sanitation.

No. 2 on this list of priorities was the promotion of maternal and child health.

I single this out not only because it is of special interest to the readers of *The Child*. It is highly significant that the first assembly of this United Nations body should put promotion of the health of mothers and children so high on its "must" list. It is even more significant that the assembly includes the mental and emotional health of children, as well as their physical health. For the first time here is a responsible international government organization that not only declares in its program that "maternal and child health is a problem of primary importance" but implements that declaration with a plan for action.

This development has large implications for maternal and child health and welfare workers in the United States. Probably in no country of the world is as much experimentation and demonstration in the field of maternal and child health now going on as right here in our own country. Through the WHO all of us will have a chance, such as we have never had before, to pass along the benefits of what we have learned from such experiments and demonstrations to the people of less fortunate lands.

Many of you, in line of duty, will be asked some time to help in spreading through the WHO what you know about good care for mothers and children. I hope, when that appeal comes to you, you will count it an opportunity, not just an extra burden.

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